

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4706	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  05/06/2011
NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTHCARE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1758 HILLWOOD DRIVE KNOXVILLE, TN 37920		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the annual Licensure survey and investigation of complaint # 27457, #27790, and #27994, conducted at Hillcrest Healthcare South, on May 2 - 6, 2011, no deficient practices were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002			

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REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE FORM

TITLE

(X6) DATE

ZTPW11

If continuation sheet 1 of 1

JUN 03 2011